GOVERNMENT
OF THE
DISTRICT OF
COLUMBIA

DEPARTMENT OF HEALTH
HEALTH REGULATIONS AND LICENSING ADMINISTRATION
PHARMACEUTICAL CONTROL
717 14th STREET, N.W., 6th FLOOR
WASHINGTON, D.C. 20005

APPLICATION FOR REGISTRATION PERMIT
Hearing Aid Dealers

1. _____ _____
NAME OF APPLICANT(S): Phone Number
2. _____ _____
NAME: Phone Number
3. _____
ADDRESS: Street and Number City State Zip Code
4. _____

5. _____ _____
TRADE NAME: Phone Number
6. _____ _____
ADDRESS OF PREMISES APPLIED FOR: Zip Code
7. _____ 8. _____
D.C. WARD NO. Certificate of Occupancy No.

9. Indicate whether a

[ ] CHANGE OF OWNERSHIP [ ] CHANGE OF LOCATION [ ] NEW APPLICATION

10. If change of Owership, give previous name:

_____

_____

11. If New Location, give:

Date Ready for Inspection_____

Date of Opening_____

12. NAME OF CORPORATION: _____ _____
Phone Number
OFFICE ADDRESS: City State Zip Code
_____
NAME OF BUSINESS
_____ _____
ADDRESS OF BUSINESS Zip Code

13. If Corporation, list Officers and Address

President:_____

Vice President:_____

Secretary:_____

Treasurer:_____

14. If Non D.C. Corporation and/or Non D.C. Resident:

Applicant's D.C. Agent

Name:_____

Address:_____

Phone Number:_____

15. Has applicant(s) been found guilty of fraudulent hearing aid practices or advertising? [ ] YES [ ] NO
If answer to above question is Yes, please attach supplemental sheet with explanation.

I CERTIFY THAT ALL OF THE STATEMENTS MADE BY ME ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND ARE MADE IN GOOD FAITH.

16. Signature of Applicant_____ 17. Date_____

Revison 10/2010